MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Inpatient Services

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Contents

Laboratory Service Frequency Limits Clarification

Retroactive to dates of service on or after January 5, 2004, laboratory services are subject to frequency limits. These limits are set per recipient, per service, per month via the Laboratory Services Reservation System (LSRS). Laboratory providers may use the LSRS to make reservations, or verify if a frequency limit has been reached for a specific recipient for a specific laboratory service prior to performing the procedure. When a reservation is made, the claim must be billed with the provider number used to make the reservation.

Frequency limits may be overridden on a case-by-case basis when the provider submits medical justification to support the frequency of the laboratory service for a recipient. Justification will be reviewed by medical review staff for final authorization. Providers are reminded that laboratory service claims that are denied due to frequency limitations may be appealed with submission of medical justification. Failure to make a laboratory service reservation prior to performing the laboratory service may result in denial of the claim.

The following entities are excluded from frequency limitations when the full laboratory service is rendered onsite: End Stage Renal Disease (Dialysis) Clinics, county public health clinics, Skilled Nursing Facilities (SNFs), inpatient hospitals and emergency rooms. The following programs are excluded from frequency limitations: California Children's Services, Genetically Handicapped Persons Program and Child Health and Disability Prevention Program.

Note: Providers are reminded that independent clinical laboratories that provide services to recipients in SNFs and dialysis clinics must adhere to the same requirements to supply their claims with further documentation in support of medical justification for rendering laboratory services to these recipients.

For an overview of the LSRS process, providers can go to:
http://pro.medi-cal.ca.gov/Docs/Elearning/LSRS3028/HTML/HOME.htm

Exceptions to Submitting CIFs

Providers are reminded not to submit *Claims Inquiry Forms* (CIFs) for the following Remittance Advice Details (RAD) code messages, unless information on the CIF specifically addresses the denial reason. For example, if the denial was 002, but an error is found in the recipient ID on the original claim, this would be an appropriate CIF, with a changed recipient ID. However, if providers wish to challenge the determination, a CIF will result in the same denial. A review by a person in the appeals unit is the only way of resolving denials if the claim has a unique circumstance needing human intervention.

Please see **Exceptions**, *page 2*

Exceptions *(continued)*

Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.

The updated information is reflected on manual replacement page cif co 2 (Part 2).

CCS/GHPP SAR Exceptions Update

Effective for dates of service on or after April 1, 2006, California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) providers need a separate Service Authorization Request (SAR) for the following drugs, factors and nutritional products:

- Anti-Inhibitors (J7198)
- Factor VIIa Recombinant (Q0187)
- Minerals/Protein Replacements/Supplements
- Sildenafil
- Tadalafil
- Vardenafil
- Von Willebrand Factors (Q2022)

In addition, effective for dates of service on or after April 1, 2006, Factor VIIa Recombinant should be billed using HCPCS code Q0187. HCPCS code Z5230 will no longer be an active code.

This updated information is reflected on manual replacement page cal child sar 6 (Part 2).

Upcoming Vision Care Changes in July 2006

As part of the continuing effort to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), the following vision changes will become effective for dates of service on or after July 1, 2006.

- **Vision Electronic Claim Submitters:**
  - Medi-Cal will **discontinue** acceptance of non-HIPAA standard electronic formats for vision claim transactions. **REGARDLESS of Date of Service**, as of July 1, 2006, the California Department of Health Services (CDHS) will no longer accept the Vision Computer Media Claim (CMC) proprietary format. Electronic claims must be billed using the HIPAA-compliant ASC X12N 837 Professional version 4010A1 format or Internet Professional Claims Submission System (IPCS).
  - ASC X12N 837 v.4010A1 Vision Companion Guide will be replaced with the ASC X12N 837 v.4010A1 Medical Companion Guide for dates of service on or after July 1, 2006. The companion guides can be found in the "HIPAA Update" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**).

Please see **Vision Care Changes**, *page 3*

Vision Care Changes *(continued)*

- **Vision Paper Claim Submitters:**
  - Paper claims must be billed on the *HCFA 1500* claim form. Medi-Cal's proprietary *Payment Request for Vision Care and Appliances* (45-1) claim form will no longer be accepted.
- **New Vision TAR Procedures:**
  - As a result of the discontinuance of the *Payment Request for Vision Care and Appliances* (45-1) claim form previously used to request prior authorization for eye appliances, a new *Treatment Authorization Request* (TAR) form (50-3) has been created for this purpose. Watch for future *Medi-Cal Updates* and announcements on the Medi-Cal Web site for details about this new form and authorization process.
- **Vision Procedural Changes:**
  - Conversion of Medi-Cal Healthcare Common Procedure Coding System (HCPCS) Level III interim codes to national HCPCS Level II and Physician's Current Procedural Terminology (CPT) Level I codes.
  - Elimination of vision qualifying codes and the use of national modifiers.

Instructor-Led Seminars for Upcoming Vision Changes
Providers can access the upcoming dates and locations for Vision Seminars by visiting the Medi-Cal Web site (**www.medi-cal.ca.gov**) and clicking the "Education & Outreach" link on the left-hand navigation bar and then the "Medi-Cal Instructor-Led Seminars" link.

Self-Service HIPAA Transaction Utility Tool
A self-service environment HIPAA Transaction Utility Tool is available for submitters. The utility tool offers transaction validation (inclusive of Companion Guide-level editing), troubleshooting and reporting features that enhance, but do not replace, Medi-Cal's current testing and media activation requirements. Vision electronic claim submitters have been notified via letter of utility availability, with instructions on how to use it.

Electronic Attachments
New attachment submission options to expedite claims processing are available to providers or submitters. Providers now have the ability to submit fax and electronic attachments with 837 v.4010A1 electronic claim submissions. This new functionality allows providers to submit electronic claims and fax their attachments, or send the attachments electronically through an approved third-party vendor. An approved list of third-party vendors available for electronic attachment submissions will be announced in a future *Medi-Cal Update.*

In addition to faxing them, providers may also send hard copy attachments by mail. For details on how to send attachments, along with the address to mail the attachments to, please refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "HIPAA" link on the home page, then the "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications" link, and then the "Billing Instructions" link.

The "837 Version 4010A1 Electronic Claims with Attachments Now Available" article published in the January 2006 *Medi-Cal Update* is also available for reference. You may access the article by clicking the "HIPAA" link on the Medi-Cal home page and then the "Electronic Transactions: Biller Updates" link.

Additional Resources
For more information, in-state providers may call the Telephone Service Center (TSC) at 1-800-541-5555, 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200.

New Vision Care Treatment Authorization Request (TAR) Process Effective July 1, 2006

Effective for vision services performed on or after July 1, 2006, the *Payment Request For Vision Care and Appliances* (45-1) claim form will no longer be used to request prior authorization for medically necessary contact lenses, low vision aids and other non-Prison Industry Authority covered items.

Instead of the 45-1 claim form, providers will use the 50-3 *Treatment Authorization Request* (TAR) form to submit prior authorization requests for eye appliances services performed on or after July 1, 2006. A draft of this form is included with this bulletin.

The 50-3 TAR form is available and can be ordered by contacting the Telephone Service Center (TSC) at 1-800-541-5555. **However, the 50-3 TAR form cannot be used to request authorization for any service performed prior to July 1, 2006.** Please continue to follow current procedures using the 45-1 claim form to request prior authorization for dates of service prior to July 1, 2006.

New Authorization Process
The current authorization process requires that an original 45-1 claim form be mailed to the Vision Care Policy Unit (VCPU) for authorization. Effective for vision services performed on or after July 1, 2006, the 50-3 TAR form and associated documentation can be mailed or faxed to:

California Department of Health Services
Vision Care Policy Unit
MS 4600
P.O. Box 997413
Sacramento, CA 95899-7413

VCPU Fax Number: (916) 552-9077

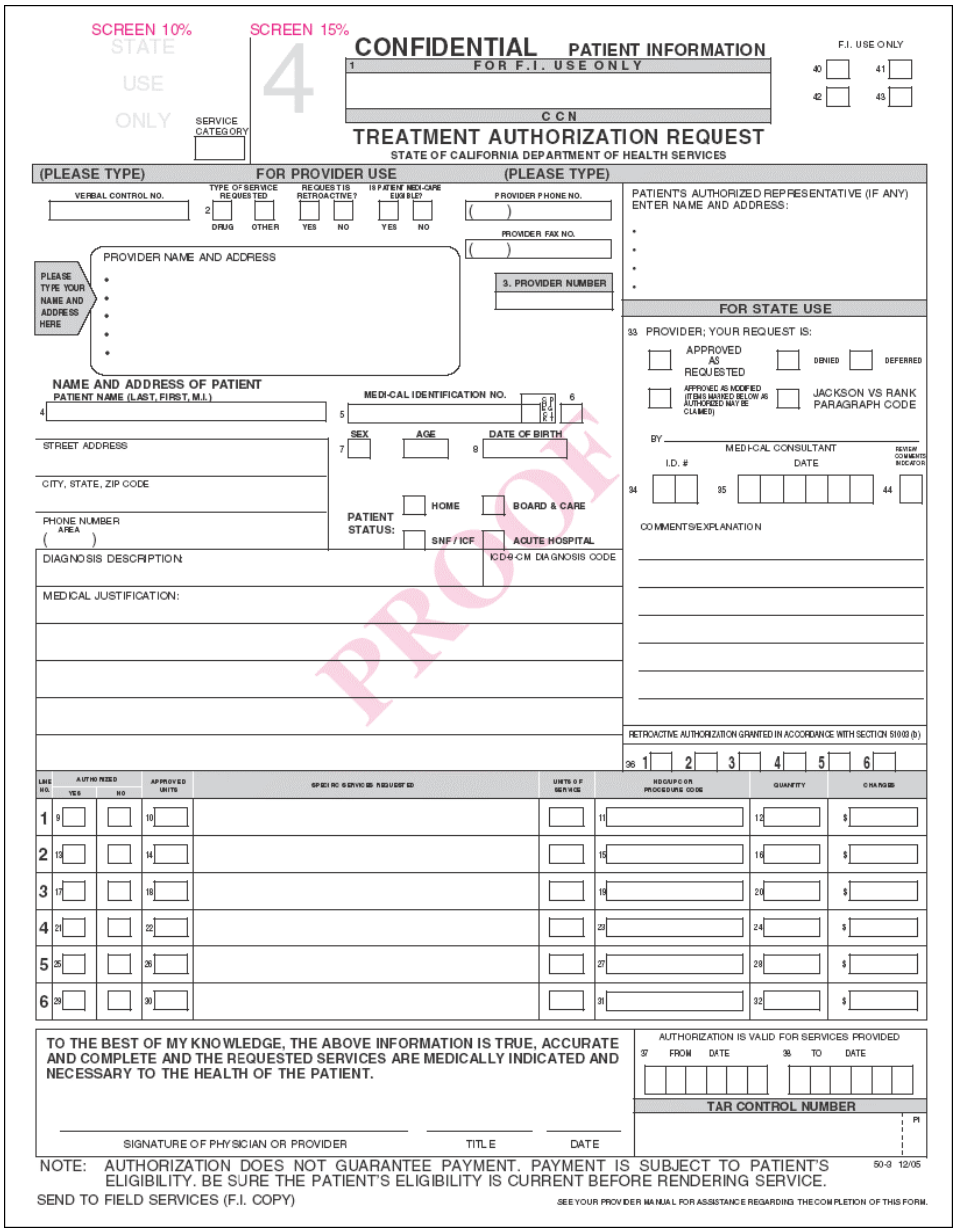
Providers should see an improved response and turnaround time for authorizations since the new TAR process allows faxed TAR submissions and responses.

Upon completion of the authorization review process, the VCPU will fax (if a valid fax number is included on the form) or mail the 50-3 TAR form back with a decision (Approved as Requested, Approved as Modified, Denied or Deferred). All TARs are assigned a TAR Control Number (TCN) and Pricing Indicator (PI) on the 50-3 form. Claims for approved services must include a valid TCN and PI for payment. The assigned TCN and PI are also required for resubmission of deferred TARs.

Specific instructions about how to use the 50-3 TAR form and how to submit claims of approved services for payment will be addressed at Medi-Cal instructor-led seminars and future *Medi-Cal Updates*. For a schedule of upcoming seminars, please call the TSC or visit the Medi-Cal Web site at **www.medi-cal.ca.gov** and click "Education and Outreach" and then "Medi-Cal Instructor-Led Seminars."

Please see **Vision Care TAR**, page 5

Vision Care TAR *(continued)*


SCREEN 10%
SCREEN 15%
STATE USE ONLY
SERVICE CATEGORY
4
CONFIDENTIAL PATIENT INFORMATION
1 FOR F.I. USE ONLY
CCN
F.I. USE ONLY
40 41 42 43
TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES
(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)
VERBAL CONTROL NO.
2 TYPE OF SERVICE REQUESTED DRUG OTHER
REQUEST IS RETROACTIVE? YES NO
IS PATIENT MEDI-CAL ELIGIBLE? YES NO
PROVIDER PHONE NO.
PROVIDER FAX NO.
PROVIDER NAME AND ADDRESS
PLEASE TYPE YOUR NAME AND ADDRESS HERE
3. PROVIDER NUMBER
PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:
FOR STATE USE
33 PROVIDER; YOUR REQUEST IS:
APPROVED AS REQUESTED
DENIED
DEFERRED
APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)
JACKSON VS RANK PARAGRAPH CODE
BY
MEDI-CAL CONSULTANT I.D. #
DATE
REVIEW COMMENTS INDICATOR
94 95 44
COMMENTS/EXPLANATION
NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)
4
MEDI-CAL IDENTIFICATION NO.
5 6
SEX
AGE
DATE OF BIRTH
7 8 9
STREET ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER AREA ( )
PATIENT STATUS: HOME BOARD & CARE SNF / ICF ACUTE HOSPITAL
DIAGNOSIS DESCRIPTION:
ICD-9-CM DIAGNOSIS CODE
MEDICAL JUSTIFICATION:
RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)
96 1 2 3 4 5 6
LINE NO. AUTHORIZED YES NO APPROVED UNITS SPECIFIC SERVICES REQUESTED UNITS OF SERVICE HCPCS OR PROCEDURE CODE QUANTITY CHARGES
1 9 10 11 12 $
2 13 14 15 16 $
3 17 18 19 20 $
4 21 22 23 24 $
5 25 26 27 28 $
6 29 30 31 32 $
TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.
SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE
AUTHORIZATION IS VALID FOR SERVICES PROVIDED
37 FROM DATE 38 TO DATE
TAR CONTROL NUMBER
PI
NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.
50-3 12/05
SEND TO FIELD SERVICES (F.I. COPY)
SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.
PROOF

New *Treatment Authorization Request* (50-3) Form

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	cal child sar 5/6
Remove:	cif co 1 thru 10
Insert:	cif co 1 thru 11
Remove and replace:	tar and non cd9 1/2 *

* Pages updated due to ongoing provider manual revisions.